FLED 1 KAMALA D. HARRIS JAN 17 2013 Attorney General of California LINDA K. SCHNEIDER Board of Vocational Nursing and Psychiatric Technicians Supervising Deputy Attorney General 3 ANTOINETTE B. CINCOTTA Deputy Attorney General 4 State Bar No. 120482 110 West "A" Street, Suite 1100 5 San Diego, CA 92101 P.O. Box 85266 San Diego, CA 92186-5266 Telephone: (619) 645-2095 Facsimile: (619) 645-2061 7 Attornevs for Complainant 8 BEFORE THE 9 BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS DEPARTMENT OF CONSUMER AFFAIRS 10 STATE OF CALIFORNIA 11 In the Matter of the Accusation Against: Case No. PT-2012-745 12 **GRACE GADDI SCHECHTER** 13 201 Zion Way Santa Ana, CA 92703 ACCUSATION 14 Psychiatric Technician License No. PT 33800 15 Respondent. 16 17 Complainant alleges: 18 **PARTIES** 19 1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in 20 her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs. 21 22 2. On or about July 27, 2007, the Board of Vocational Nursing and Psychiatric 23 Technicians issued Psychiatric Technician License Number PT 33800 to Grace Gaddi Schechter 24 (Respondent). The Psychiatric Technician License was in full force and effect at all times 25 relevant to the charges brought herein and will expire on March 31, 2013, unless renewed. 26 /// 27 /// 28 /// 1

JURISDICTION

- 3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.
- 4. Section 4520 of the Code provides, in pertinent part, that the Board may discipline any licensed psychiatric technician for any reason provided in Article 3 (commencing with section 4520) of the Psychiatric Technicians Law (Code § 4500, et. seq.)
- 5. Section 4545 of the Code provides, in pertinent part, that the Board may renew an expired license at any time within four years after the expiration.
- 6. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, and/or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY AUTHORITIES

7. Section 4521 of the Code states:

"The board may suspend or revoke a license issued under this chapter [the Psychiatric Technicians Law (Bus. & Prof Code, 4500, et seq.)] for any of the following reasons:

- "(a) Unprofessional conduct, which includes but is not limited to any of the following:
- "(1) Incompetence or gross negligence in carrying out usual psychiatric technician functions.

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REGULATIONS

- 8. California Code of Regulations, title 16, section 2576.5 states in pertinent part:
- "The licensed psychiatric technician performs services requiring technical and manual skills which include the following:
- "(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the

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1	belief that there was a conscious disregard or indifference for the health, safety, or welfare of the											
2	consumer shall be considered a substantial departure from the above standard care."											
3	COSTS											
4	11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the											
5	administrative law judge to direct a licentiate found to have committed a violation or violations of											
6	the licensing act to pay a sum not to exceed the reasonable costs of the investigation and											
7	enforcement of the case, with failure of the licentiate to comply subjecting the license to not being											
8	renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be											
9	included in a stipulated settlement.											
0	FACTUAL ALLEGATIONS											
1	12. Respondent was employed by Fairview Developmental Center ¹ (FDC) beginning in											
2	2002. She became employed as a psychiatric technician there beginning in or about 2007.											
3	13. On December 13, 2007, Respondent received training on Cardiopulmonary											
4	Resuscitation (CPR) at FDC.											
5	14. The California State Personnel Board's Psychiatric Technician Job Specifications											
6	includes the following:											
7	"Typical Tasks:											
8	" gives a basic level of general behavioral and psychiatric nursing care performs											
9	nursing procedures gives first aid as needed.											
20 .	"											
21	"Knowledge And Abilities:											
22	"Knowledge of:											
23	" fundamentals of nursing care current first aid methods cardiopulmonary											
24	resuscitation "											
25	Fairview Developmental Center is one of five state-operated developmental centers											
26	operated by the Department of Developmental Services. FDC is a multi-service residential facility licensed by the California Department of Public Health to provide acute, skilled, and											
27	intermediate care to individuals with developmental disabilities who need 24-hour health care supervision, a structured environment, and a habilitation program not currently available in their											
28	home community.											

	15.	Sectio	n 1.5.2					_	_	Client	Rights"	states,	in part	, tha
		. 1.				1.00	11 12 1	* * * * *						
all c	lients l	nave "A	right t	o be fr	ee fro	m harn	n abı	ise or no	eglec	t.''				

16. Section 1.6 of the FDC Policy Manual regarding "Treatment of Clients" states, in part:

"The fundamental responsibility of every employee is to ensure the safety and well-being of individuals who live at the Center. Any form of neglect or abuse is expressly prohibited. ...

Employees must constantly be alert to ensure that individuals served are not mistreated, neglected or abuse in any way by any person.

"

"Neglect: is defined as the negligent treatment or maltreatment of a person, which indicates harm or threatened harm to an individual's health or welfare. This includes the intentional failure to provide ... medical care and supervision. Conditions which may indicate neglect include but are not limited to:

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- "b. Medical lack of adequate medical/dental care. Examples include: not taking action on medical problems. ...
- "c. Abandonment the desertion or willful denial of service to a client by anyone having care or custody of that person."
 - 17. Section 5.5.3 of the FDC Policy Manual states, in part:

"Staff are to account for the location of assigned clients at all times, provide supervision consistent with individual needs, and implement identified strategies to provide risk management/client protection."

18. On February 22, 2009, Respondent was assigned to Residence 529 (R-529) as the lead psychiatric technician (PT) during the evening shift that was scheduled to start at 2245 hours. The relief process for the evening shift started at 2245 hours. According to FDC Nursing Procedure 7.11, the oncoming shift is required to complete rounds with the off going shift prior to being relieved, and complete a "Shift Change Report." The oncoming shift lead is the only person authorized to release the off going staff.

Office of Protective Services (OPS) Case No. DS09-02-F-032-F²

- 19. Respondent arrived at the Nurses' Station on R-529 at approximately 2240 hours. When she left the Nurses' Station at or about 2247 hours, the evening (PM) shift had already left. M.N. was the PM shift charge. Respondent did not meet with the PM shift charge at the shift change. At approximately 2250, Respondent, the oncoming or nocturnal (NOC) shift lead, went to client Danisha's room to toilet Danisha's roommate. Danisha was a 16-year-old female with an IQ of 53. She suffered from bipolar and somatoform disorders, and was in the mild range of mental retardation. Danisha was limited verbally, and used body language, body gestures, and emotional-based facial expressions to communicate.
- 20. As Respondent approached the room, she observed that no one was monitoring the female's hallway and the hallway door was closed, which was very unusual. She entered Danisha's room and found her unconscious under a neatly folded blanket. Danisha had a lotion-type substance in her eyes, foreign objects in her mouth and nostrils, two missing teeth and blood coming from her mouth, scratches on her chest, and a cord lying across her neck. Respondent panicked, and ran to the Nurses' Station looking for the PM shift charge, M.N. Another PT advised Respondent that the PM shift charge had already left. Respondent directed the PT to call "77," a medical emergency. The PT then went to Danisha's room and began CPR on her.
- 21. At approximately 2257 hours, on February 22, 2009, a special OPS investigator, who was working overtime as a patrol officer at FDC, was called to assist at a medical emergency at R-529. Upon arrival, the investigator observed another PT performing cardiopulmonary resuscitation on Danisha. Danisha was transported to a local hospital, where she was placed on a ventilator. A CAT-scan was performed on Danisha the following morning, and it was determined that she had anoxic encephalopathy (brain damage due to lack of oxygen). A brain-flow study performed later in the day revealed that Danisha was brain dead. Danisha's mother agreed to

² The Office of Protective Services (OPS) delivers a full range of public safety services including basic policing, investigations, and fire safety services to the Department of Developmental Service's developmental centers and state-operated community facilities. A special investigator for the OPS was assigned to conduct an abuse/neglect investigation on February 23, 2009, which became a death investigation when FDC client Danish died that evening.

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have the respirator removed, and Danisha was pronounced dead at 1950 hours on February 23, 2009. The county coroner ruled Danisha's death a homicide. Another developmentally disabled client was later identified as the primary suspect in Danisha's death.

22. Based on interviews with FDC employees, the OPS investigation revealed that the prior shift lead PT allowed staff members to leave at or prior to 2245 hours. Respondent did not conduct a verbal relief with the prior shift lead at the shift change. No shift change inspection was conducted. No Shift Change Report was prepared. Respondent admitted that after finding Danisha unresponsive, she did not immediately initiate CPR because she panicked, and ran to the Nurses' Station. Respondent also admitted that she was aware of the CPR protocol, but failed to implement the CPR protocol because she panicked.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is subject to disciplinary action under section 4521, subdivision (a)(1) of the Code, as defined by California Code of Regulations, title 16, section 2577, in that on or about February 22, 2009, Respondent performed her psychiatric technician duties in a grossly negligent manner as set forth in paragraphs 12 to 22, which are incorporated here by this reference. Respondent's conduct was an extreme departure from the standard of care in that she failed to initiate CPR upon finding Danisha unresponsive, and when she failed to return to Danisha's room to assist with life saving measures. Respondent's willful failure to follow FDC's published protocol and procedures on which she was trained constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to disciplinary action under section 4521 in that she engaged in unprofessional conduct in that on or about February 22, 2009, Respondent failed to initiate CPR upon finding Danisha unresponsive, and failed to return to Danisha's room to assist with life saving measures in violation of California Code of Regulations, title 16 sections 2576.5 and 2576.6, as set forth in paragraphs 12 to 22, which are incorporated here by this reference.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

- 1. Revoking or suspending Psychiatric Technician License Number PT 33800 issued to Grace Gaddi Schechter
- 2. Ordering Grace Gaddi Schechter to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and
 - 3. Taking such other and further action as deemed necessary and proper.

DATED: <u>January</u> 17, 2013

TÉRESA BÉLLO-JONÉS, J.D., M.S.N., R.N.

Executive Officer

Board of Vocational Nursing and Psychiatric Technicians

Department of Consumer Affairs

State of California

Complain ant